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AUTHOR Bullough, Vern; Bullough, Bonnie
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ABSTRACT

The implications for nursing education of the fact that nursing started as a woman's occupation in a field dominated by the male physician are considered. Although in 1873 nursing represented a real educational opportunity for large numbers of women, none of the prestigious women's colleges were interested in educating women for careers. In the nineteenth century, few medical schools demanded as much as a high school diploma for admission. Since the best physicians trained in hospitals, it was inevitable that nurses be trained there also. Hospitals expected work from the nursing students, and the system was based more on an apprenticeship model than an instructional one. Control by nurses was weak since physicians tended to administer hospitals. Nurses were taught that the physician's word was law and that they knew much more, even though the nurse constantly observed the patient and the physician was limited to short visits. Nurses who attempted to break out of the system were often punished. Patterns of subservience and feminine submissiveness led to an undervaluing of the contribution of nurses, which is reflected in the salary schedule and job prerequisites. Nursing education today can best be understood in the context of traditional and changing male-female role playing. Appended is "Nurses and Women Physicians: The Case of Ida May Wilson" (1864-1955), by Vern L. Bullough. (SW)

Women Nurses and Male Physicians: Their Educational Relationships

Vern Bullough

Bonnie Bullough

ABSTRACT

Modern American nursing started as a woman's occupation in a field dominated by the male physician. This paper examines the implications of this for nursing education and highlights the struggle to achieve independent control and self identity The authors conclude that current developments in nursing education cannot be understood without some understanding of the historical setting of male-female role playing and the changes taking place in this.

WOMEN NURSES AND MALE PHYSICIANS: THEIR EDUCATIONAL RELATIONSHIPS

Vern Bullough, RN, Ph.D., Bonnie Bullough RN, Ph.D

Because modern nursing developed as a woman's profession, it suffered all the handicaps that women suffered as well as the problems of an emerging profession. One of the most obvious forms of discrimination practiced against women in the nineteenth century was denying them educational opportunities. Education, or at least advanced education, was a male privilege, and only a few women were able to break through this male bastion. Though there had been various female seminaries, the first coeducational institution of higher education in the United States was Oberlin College, founded in 1833. Oberlin was an exception and higher education largely remained male until after the Civil War. The first woman's college, then known as Mount Holyoke Female Seminary, was established in 1837, but it technically was not chartered as a college until 1888. The other six major women's colleges were post Civil War establishments: Vassar, 1865, Smith and Wellesley, 1875, Radcliffe, 1879, Bryn Mawr in 1885, Barnard in 1889. In short nursing in 1873 represented a real educational opportunity for large numbers of women.

Yet none of the prestigious colleges for women ever established a nursing school (except Vassar briefly during World War I), and in fact were not interested in educating women for any kind of careers. Instead they concentrated on the liberal arts and in effect downplayed the emerging women's professions if not ignoring them entirely. Women teachers who also needed specialized education were for the most part taught in normal schools until after World War I. Normal schools were not colleges, and in most states were the equivalent of high school. Only a few particularly enlightened colleges offered baccalaureate degrees to elementary school teachers. Social

work was also out of the educational mainstream and when it entered the university it did so as a graduate school in a few select universities. Though this made it socially more acceptable for upper middle class women, it lacked the career opportunities for its graduates that nursing offered. Library work was also offered in special institutes during the last part of the nineteenth century and first part of the twentieth century, and faced many of the handicaps that nursing did. In fact many of the leading librarians never received a degree in library science but moved into the field from others.

Even if colleges were not quite so discriminatory to women, however, nursing would have had difficulty in moving onto the college campus because medicine was not yet there. This leads us to the interrelationship of nursing and medicine, a subject as important in shaping its direction as the fact that it was a woman's profession. Though the United States had a number of medical colleges in the nineteenth century, most were colleges in name only. Few of the medical schools demanded as much as a high school diploma for admission, and none required a bachelor's degree. Many of the medical programs lasted only two years, and some lasted only six months. It was not until 1893 when the Johns Hopkins Medical School was founded that medicine was established on a graduate level, and as late as 1905 only five of the 160 medical schools required any kind of college work preparatory to admission. Though some of the colleges such as the Harvard Medical College had nominal college or university affiliation, the distinguishing match of the better schools was their tie with a hospital. Most medical colleges lacked a hospital connection and were what were known as proprietary schools, that is private business run for profit, lacking

university standards, facilities, or ideals. Americans who wanted the advanced training went to Europe for their medical education, a trend that continued until the end of the first World War when American medical schools began to match and even surpass their European counterparts.

Medicine was also divided into various sects based on their theoretical approach to treatment; homeopaths, eclectics, osteopaths, alleopaths, et al. Theoretical orthodoxy was more important than content and of the 160 medical schools in 1903 many were little more than diploma mills, without entrance requirements, hospital connections, or even teaching laboratories. Though some reforms had been introduced into medical education, public attention was effectively focused upon the need for reform by the study of Abraham Flexner, who, under the sponsorship of the Carnegie Foundation, made recommendations to bring medicine to the status of a true graduate discipline. Flexner found that in 1910 only 680 or 15.3 percent of the 4,440 medical graduates had a bachelor's degree when they received their doctorate, a number which has risen to 43.5 percent or 15.3 percent of the 4,440 medical graduates by 1920. (It should be added that most earned their bachelor's degree while getting their doctorate.)[1] On a practical level, nursing training, as weak as it was in the nineteenth century was often superior to the training of physicians since many medical students lacked actual hospital training until this century. I should add that this is still true of many foreign trained doctors practicing in this country now.

Since the best physicians trained in hospitals, it was inevitable that nurses be trained there as well. This was also the Florence Nightingale model (English physicians were also trained in hospitals). The English model training school established by Nightingale received a major impetus

in the United States with the opening of Bellevue Hospital in school in May 1873, followed in October by the Connecticut Training School in New Haven, and in November by the Boston Training School at Massachusetts General. All three schools as well as most which followed in the next half century claimed to be based upon the Nightingale model, but the use of the model was highly selective. Although some of the early training schools had funds to start, none of them were endowed and most were not adequately financed. This meant that the hospitals expected work from the students, and the system followed much more of an apprenticeship model than an instructional one. Many hospitals did not even allow the minimal lecture series given at Nightingale's St. Thomas (weekly lectures), nor did the hospitals contract to employ their graduates after training as they did in England. Instead they relied primarily upon student nurses for running the hospitals, and the nurses who graduated had their names listed on a registry to do private duty or went into nursing administration or education. At first course work was only included in one of the years. The Illinois Training School for Nurses in 1887 was the first school to extend course work for the two years of nurse training. Early nursing classes often were a mismash since the schools did not separate their students by prior education until after 1900 when the academically stronger schools demanded high school and graduation and stopped paying students a stipend. This led to some selective recruitment of more affluent and better prepared students into the stronger schools, since poorer students who often lacked the educational background needed the stipends.[2]

From the first there was a question of control of nursing education. In England control clearly lay in the hands of the nurses. In this country,

matters were not so clearly differentiated, and there always was much more hospital control. In part this was due to the influence of Johns Hopkins Hospital which debated between the so called Waltham Plan which was a physician controlled nursing school in Waltham, Mass., predating the Nightingale school, and the Nightingale plan. Johns Hopkins set up a kind of compromise with the nursing school placed under the hospital board of trustees rather than under a separate board of nursing education, but a nurse was made superintendent of the school and the hospital nursing service. This pattern was widely adopted but actual control by nurses was weak since the physicians tended to become hospital board members and executives while nurses did not.

Inevitably almost every progressive step involved some conflict with the medical profession. It also meant that nursing followed behind medicine, picking up the pieces that medicine had left. After medicine moved into the colleges and universities, nursing could begin to do so, but the difficulty was that the power figures in medicine, usually the older generation of physicians, kept remembering nurses as they had been when the physicians were younger. They tended to forget that the nature of medicine changed. Typical is Charles Mayo, the founder of the Mayo Clinic in Rochester, Minn. His denunciation is important because the university of Minnesota had established the first nursing program with any connection with a university just before World War I. Though the Minnesota plan was only a partial beginning, it did give nurses more education than they had had before, and as this movement began to spread it led to Mayo's denunciation. In 1921 he protested such rising educational standards for

nurses, claiming that nurses in their pursuit of higher learning had lost sight of the real impulse of their profession:

> the alleviation of the pain of the world. Ministration to the sick and the dying can not be bound by hard-and fast-laws. They are the divine right of the poor as well as the rich. A prohibitive price can not be put upon them. And that is what the nurses are doing. Too great a commercialization of their services is making proper care of the sick impossible for those in moderate circumstances.[3]

He urged a lowering of educational standards, the abolition of requirements for high school education, and the rapid training of a group of "sub" nurses to take over the jobs now done by those over-educated nurses.

Periodically similar denunciations appear. In 1968 the New England Journal of Medicine ran an article by a physician, Thomas Hale of the Albany Medical Centre Hospital, condemning the attempt by nurses to further upgrade their nursing education by establishing master's level education and trying to eliminate non-college affiliated hospital schools.[4] Both authors were elderly, and in fact Hale was retired. Inevitably nurses coped with such denunciations by males, and they are almost always males, by playing the male-female game. As they extended their skill and upgraded their education, they had to do so without antagonizing the powerful, i.e. male physicians, more than a bare minimum. Part of the difficulty is that women traditionally have been socialized to act in certain ways to men, to play what has often been described as the male-female game. The rules for this traditional game have been described in all seriousness, and in retrospect most effectively, by the anti-feminist Helen Andelin in her book, Fascinating

Womanhood.[5] Mrs. Andelin, the name she prefers to use, urged women to avoid confronting a man directly, not to contradict him, and above all never to denigrate his masculinity. Instead the woman was supposed to use feminine wiles to achieve her end, even if this entailed acting the role of a little girl in which a /grown/ woman would stamp her feet, shake her curls, and even break into tears. Though nurses never quite adopted the ideal female role projected by Mrs. Andelin, the role prescription was such that they played their own variant version of the game.

A poem which ran in the nineteenth century nursing journal indicates that this pattern was set early since it included the lines:

Nurses moving quietly,
Voices hushed in awe,
All things silent waiting,
Obedient to the law
That we have heard so often,
But I'll repeat once more
"All things must be in order
When Doctor's on the floor."[6]

Nurses were taught that the physician's word was law, that nurses were to stand when they entered the ward or the room, and that it would be rude for nurses to speak to physicians openly and honestly or to even offer suggestions about the nursing care of the patient, a subject which they knew much more about than anyone else. In fact if a patient asked a question, the answer to which was known by the nurse, the nurse always was supposed to respond "Ask your doctor."

Such behavior is contrary not only to the reality of the nursing situation but the welfare of the patient. Ordinarily the physician only sees the hospitalized patient for a few minutes each day; he has to depend upon someone for the information and this someone is usually the nurse. But the nurses who assess the patient twenty-four hours a day act as if they have never been able to diagnose an illness, but instead are forced to adopt the fantasy that the doctor is and should be omniscient and omnipotent.

Nurses observe the patient's condition hours after hours, they have a chance to hear what he or she has to say. They know when to intervene and when not to intervene and when to ask the physician for permission to intervene. Under the rules of the old doctor-nurse game, however, nurses had to pretend that they never diagnosed or made recommendations. The game was well described by the psychiatrist Leonard Stein in 1967. He was fascinated by the strange way in which nurses made suggestions to physicians so that both the physician and the nurse could pretend recommendations had not been made. He called the pattern a transactional neurosis.[7]

A good example was observed fifteen years ago by one of the authors of this paper in her supervision of students on a medical floor. Many of the patients on the ward were seriously ill cardiac patients receiving digitalis or related synthetic drugs. The dosage for these drugs, as all nurses know, has to be adjusted to the individual patient and since the therapeutic dose is close to the toxic dose, the patient must be observed carefully for symptoms of toxicity, particularly when the patient is being first digitalized. The conscientious and knowledgeable nurses on the ward observed the patients for symptoms of such toxicity as indicated by a slow pulse rate, nausea, or depression. Nurses read the monitors and could easily

identify the characteristic cardiac arrhythmias that suggested this type of toxicity. When they noted symptoms of developing toxicity they would immediately withhold the drug and then notify the physician, not of their actions but of their observation. In fact they would not dare tell a physician they had noted symptoms suggesting toxicity, they would simply report the discrete symptoms as if they did not understand the implications. The doctor would then tell them to withhold or lessen the digitalis dosage, and they would thank him for the "order."

If, however, the physician was a new resident or for other reasons did not appear to understand the implications of what the nurse was reporting, the nurse would "accidentally" later drop the information about the symptoms in a conversation with a third-year resident or an attending physician, and the hapless young physician would be in trouble for not acting on the nurses' observation. Thus even though the nurses made a decision and acted, they avoided at all costs the responsibility for their decisions.

Though we criticize nurses for doing this, those nurses who attempted to break out of the system were often punished. This shows up even in fictionalized accounts. One of the more famous series of medical novels was the Dr. Kildaire series which has served as the basis of a number of movies and television series. One of the key characters was the irascible Dr. Gillespie, originally played by Lionel Barrymore, who constantly and consistently put down nurses. When the nurse asked him what certain tests revealed about a patient going for surgery, his response:

> "I'm not in the habit of confiding in our nursing staff about things which can't possibly concern them. Shall we leave it at that?"

"Certainly, doctor."

In yet another story a nurse is transferred to care for a patient at the doctor's request. She comes in on her evening off to begin the case. Soon afterward the doctor appears and begins to shout:

> "You were to phone me a half hour ago, nurse. I received no phone call. !!!!!" Veronica's lips tightened. "No-one told me I was supposed to phone you doctor."
>
> He said, his voice edgy with sarcasm, "Can you read nurse? It's written on the chart"...She flushed. "I'm sorry, doctor, I guess I missed seeing it." Veronica felt anger rising in her. He had no right...! she hadn't been careless! Still... she should have seen that notation. She succeeded in holding back her anger. "No, doctor." "Next time," he said, "see if you can perform your functions as a nurse, the way they should be performed!" Veronica's lips tightened, but she managed to say, past their trembling, "Yes, Doctor."[8]

Such patterns of subservience and feminine submissiveness led to an undervaluing of the contribution of nurses. This is reflected in the salary schedule, in the perquisites of the job, and in numerous other ways.

Inevitably what nurses tended to do was to isolate themselves from medicine, to surround nursing with a barrier, arguing that this was their turf, and this had great influence on nursing education. Inevitably this also implied that any nurse who strayed beyond would be punished. There was a line between medicine and nursing and in order to keep the physicians from crossing into their area, they prevented nurses from crossing into medicine. This is exemplified by the 1955 Model Practice Act adopted by the Board of

Directors of American Nurses' Association. Included in this was a description of the nursing roles which concluded that in no ways should any of the description be "deemed to include any acts of diagnosis or prescription of therapeutic or corrective measures."[9] What this did was to deny in effect what nurses were doing in order to avoid a conflict with medicine. Since this was contrary to reality the enforcement of this disclaimer by various state attorney generals is now wreaking havoc on nursing practice.

Even before the disclaimer was adopted, some nurses, particularly those in university positions, were evolving an ideological position trying to separate the function of nurses from that of physicians. What these nurses did was to emphasize the social and psychological components of nursing at the expense of the physical and then claim jurisdiction over the social and psychological. Ultimately the major reason for the disclaimer, at least in my opinion, was the alienation or what might be called anticipatory self-discriminatory behavior of nurses. Rather than risk a possible boundary dispute with medicine, nurses either consciously or unconsciously decided to avoid admitting their role in the patient care decision making process. Similar patterns of anticipatory self-discrimination are a fairly common phenomenon among minority groups; the ghetto walls are often as well policed from the inside as from the outside and in the past feelings of powerlessness and fear have often prevented people from challenging discriminatory practice. Though understandable such behavior is harmful not only to nursing but to the patient.

Time does not stand still and in the past fifty years medicine has changed from what might be called a care and comfort occupation into a life saving activity. It has shifted from a supportive profession to a therapeutic

one. Physicians simply do not do things that they used to do. Instead it is the nurse who has developed the clinical specialties, the general practice skills, the specialized skills to extend her role as medicine retreats and advances. The physician, however, has been reluctant both to recognize the changing nature of professional change, and the physician's growing dependence upon others. Hospitals still cater to physicians, the insurance industry follows their bidding, even the government by refusing to put the kind of controls on their activity that it puts over every other occupational group, follows suit.

It is in this situation that nursing is trying to find itself. To redefine what professionalism is, to distant itself from medicine in a rational way, yet to meet the needs of the patients and the public. Previous attempts to do this have not been particularly successful but the woman's movement has had one benefit. It has made nurses conscious of their own power, of the games they play, of the difficulties that they face. They have made real progress in the past few years; the problem is how in the politics of the situation nursing can redefine itself honestly without threatening medicine too much. The key is what will happen in nursing education. Perhaps as nursing becomes less feminine and medicine less masculine, they can adopt a more honest relationship about what they both contribute to patient welfare.

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NURSES AND WOMEN PHYSICIANS: THE CASE OF IDA MAY WILSON

Vern L. Bullough

Many of the women physicians of the last part of the nineteenth century were closely allied with nursing. Elizabeth Blackwell and Marie Zakrzewska, for example, are well known to nurses for their support of nursing. Many women physicians served as nurses in the American Civil War and it was not until almost the twentieth century that women were better integrated into the medical profession. Even then there were difficulties which are effectively illustrated by the incomplete autobiography of Ida May Wilson (1864-1955) in the Ohio State University archives, a part of which was published by John B. Gabel (1978).

One of the things that appears evident in Dr. Wilson's brief life sketch of herself is the inadequacy of medical education. In fact there was not very much difference between the education that many nurses received and those given physicians, and many of the better nursing schools had higher standards of admission than the medical schools. Wilson attended the Ohio Medical University in Columbus in the period between 1894-1896. Prior to entering the "university" she had gone to school for five years in a one-room schoolhouse, and then had become too ill to continue attendance. She had stayed on the family farm until the death of her father in 1893 whereupon she moved to Columbus where her brother, Edwin Frazer Wilson, had established himself as a prominent physician. After discussing her economic condition with her brother, the two decided that in order for Ida to gain some economic independence, she should attend medical school. There were no entrance exams,

only an ability to read and write. Looking back on her education some fifty years later she wrote:

> There were very few professors, as they wished to be called, that were at all like teachers. In fact they often did not know their subject as well as some of the better students in the class. . . .The O.M.U. was formed by disgruntled men who had taught in Starling Medical School and the old Columbus College of Medicine and every physician who paid $250 was put in as a professor of something, whether he knew his subject or not. . . The man Dixon who attempted to teach general medicine. . .had not read up on his subject since he left school. . .The study of bacteriology was in its infancy, and in our class the microscopes were locked up; so we had no chance to see a germ that was known even in those days. . .I often knew the M.D.s were wrong but lacked the nerve to call them down. . .Our man Dr. Snyder, who taught us chemistry, taught us the same thing every week. . .If you studied you learned; if you expected to learn by being taught, that was something else. . .

Many of the students worked to support themselves, and in effect the medical school was little more than a part-time one. Still Ida persevered and graduated, but when she set up practice, she found she could not attract patients who paid, just plenty of charity cases. She finally took a job as superintendent of nurses at a hospital in Charlotte, North Carolina, where she worked for a

year (1898-1899) even though she had had no experience as a nurse. She felt nursing was what she really wanted, and returned to Columbus in June, 1899, planning to become a nurse. She wrote to several of the major hospital schools about entering nurses training but before the letters were mailed her brother saw them. He quickly summoned her to his office where he berated her for deserting medicine. Among other things he asked:

> Why do you want to be training for a nurse? You have your profession, learned after three long years of study. I have watched you long enough to know that you will make a physician if you will just stick to it. A nurse is on duty twenty-four hours out of the day. In medicine you make a visit and leave your orders and let the others take the worry. You will not make a fortune in medicine, no one does; but in time you will make a living. But it will come slow. You can be here in my office without any expense to you. My books, my instruments, my drugs are all here for your use. So just cut out right here the idea of being a nurse.

Unwilling to confront her brother, she decided to remain a physician and continued to practice in Columbus until after World War II, by which time she was in her eighties. When she died in 1955 her papers ended up at Ohio State University since the Ohio Medical University which she had attended was merged in 1907 with the Starling Medical College and in 1914 the merged school became the College of Medicine of the Ohio State University. It seems clear from her description that there was little difference between nurses and physicians. Nurses worked harder and took

orders from physicians who knew little more than they did. Nurses, however, were women, and physicians were men, and it says much about medicine and nursing that a woman physician would feel far more at home among nurses than physicians. It also emphasizes that much of the struggle that nurses have had in achieving professional identity is not that they were less educated than the physicians, but primarily because they were women. The education of physicians did upgrade itself more rapidly than did nursing in the middle part of the twentieth century but even here the failure of nursing to move quite as rapidly as medicine was probably due more to the fact that they were women than anything else.

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